

**STATE OF NEW YORK  
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE  
WITH SPECIAL NEEDS**

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**FINAL  
DETERMINATION  
AFTER HEARING**

**Adjud. Case #:**

[REDACTED]

Vulnerable Persons' Central Register  
New York State Justice Center for the Protection  
of People with Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
Appearance Waived

New York State Justice Center for the Protection  
of People with Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
By: Todd Sardella, Esq.

[REDACTED]  
[REDACTED]  
[REDACTED]

██████████

The Findings of Fact and Conclusions of law are incorporated from the Recommendations of the presiding Administrative Law Judge's Recommended Decision.

**ORDERED:** The request of ██████████ that the substantiated report dated ██████████, ██████████ be amended and sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 3 act.

NOW, THEREFORE, IT IS DETERMINED that the record of this report shall be retained by the Vulnerable Persons' Central Register, and will be sealed after five years pursuant to SSL § 493(4)(c).

This decision is ordered by David Molik, Director of the Administrative Hearings Unit, who has been designated by the Executive Director to make such decisions.

**DATED:** April 6, 2016  
Schenectady, New York

  
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David Molik  
Administrative Hearings Unit

**STATE OF NEW YORK  
JUSTICE CENTER FOR THE PROTECTION OF PEOPLE  
WITH SPECIAL NEEDS**

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In the Matter of the Appeal of

[REDACTED]

Pursuant to § 494 of the Social Services Law

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**RECOMMENDED  
DECISION  
AFTER  
HEARING**

**Adjudication Case #:**

[REDACTED]

Before:

Sharon Golish Blum  
Administrative Law Judge

Held at:

Adam Clayton Powell Jr. State Office Building  
163 West 125th Street  
New York, New York 10027  
On: [REDACTED]

Parties:

Vulnerable Persons' Central Register  
New York State Justice Center for the Protection  
of People with Special Needs  
161 Delaware Avenue  
Delmar, New York 12054-1310  
Appearance Waived

New York State Justice Center for the Protection  
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161 Delaware Avenue  
Delmar, New York 12054-1310  
By: Todd Sardella, Esq.

[REDACTED]  
[REDACTED]  
[REDACTED]

## **JURISDICTION**

The New York State Vulnerable Persons' Central Register (the VPCR) maintains a report substantiating [REDACTED] (the Subject) for neglect. The Subject requested that the VPCR amend the report to reflect that the Subject is not a subject of the substantiated report. The VPCR did not do so, and a hearing was then scheduled in accordance with the requirements of Social Services Law (SSL) § 494 and Part 700 of 14 NYCRR.

## **FINDINGS OF FACT**

An opportunity to be heard having been afforded the parties and evidence having been considered, it is hereby found:

1. The VPCR contains a substantiated report dated [REDACTED], [REDACTED] of neglect by the Subject of a Service Recipient.

2. The Justice Center substantiated the report against the Subject. The Justice Center concluded that:

### **Allegation 1**

It was alleged that on [REDACTED], at the [REDACTED], located at [REDACTED], while acting as a custodian, you committed neglect when you failed to provide proper supervision, during which time service recipients were left unattended in a vehicle that started to roll while parked.

This allegation has been SUBSTANTIATED as Category 3 neglect pursuant to Social Services Law § 493(4)(c).

3. An Administrative Review was conducted and, as a result, the substantiated report was retained.

4. The facility, the [REDACTED]<sup>1</sup>, located at [REDACTED]

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<sup>1</sup> Subsequent to the time of the alleged neglect, the facility's name was changed to the [REDACTED].

██████████, is operated by the ██████████  
██████████<sup>2</sup>, which is licensed by the New York State Office of Mental Health (OMH).

The OMH is a provider agency that is subject to the jurisdiction of the Justice Center.

5. The facility has sixty-four residents and it provides residential treatment to individuals who are between thirteen and twenty-one years of age, and who have primary psychiatric diagnoses. (Hearing testimony of CPI Coordinator ██████████)

6. At the time of the alleged neglect, the Subject had been employed by the facility as a Senior Milieu Counselor for ten years and her regular employment schedule was ██████████  
██████████. (Hearing testimony of the Subject) The Subject was a custodian as that term is so defined in Social Services Law § 488(2).

7. On the date of the alleged neglect at approximately 11:30 a.m., the Subject was instructed by the facility Administrator On Duty (AOD) to use one of the facility's twelve passenger vans to transport four Service Recipients to their respective homes in the ██████████ and ██████████ for the ██████████. (Hearing testimony of the Subject)

8. The Subject was concerned that another staff member had not been assigned to assist her. The Subject concluded that without another staff member present, the staff to service recipient ratio, would not comply with facility policy. A facility policy also requires that when service recipients go on home visits, their medication is to be given directly to the receiving adult. For that reason, the Subject wanted another staff member present so that she could wait in the van, while the other staff member escorted the service recipients to their homes and handed the medication directly to the receiving adults. (Hearing testimony of the Subject)

9. The Subject also raised the concern that, because of the distances involved and the

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<sup>2</sup> Subsequent to the time of the alleged neglect, the name of the facility's operator was changed to the ██████████.

heavy traffic associated with the [REDACTED], she would not be able to return to the facility before the conclusion of her shift. This was a concern of the Subject because she had planned to obtain a medical prescription, have the prescription filled, and to take her medication that afternoon. The AOD responded to the Subject's concerns by telling her that the first stop was in the [REDACTED] near an area where the Subject might obtain her prescription. This prompted the Subject to telephone her mother and arrange for her mother to pick up her prescription from her doctor. The Subject made a plan to stop at her mother's home along the way to pick up the prescription. (Hearing testimony of the Subject and Justice Center Exhibit 6 at page eight)

10. At approximately 12:30 p.m., the Subject, the four Service Recipients and another Service Recipient, who came along for the ride, left the facility in the van. (Hearing testimony of the Subject)

11. The first stop that the Subject made was in the [REDACTED] to pick up the prescription from her mother. The Subject parked the van on [REDACTED] and exited the van, leaving the keys in the ignition with the engine running and the five Service Recipients in the van. The Subject had not gone far and was speaking to her mother in a parking lot near her mother's home when the van began to roll. One of the Service Recipients jumped into the driver's seat and a nearby pedestrian instructed him to step on the brakes but the Service Recipient did not know how to do that. Thereafter, as the van continued to roll, all of the Service Recipients jumped out of it through the only unlocked door, at the front of the van<sup>3</sup>. The pedestrian quickly entered the van, applied its brakes, drove the van back into a parking spot, turned it off, and removed the keys from the ignition. At that point the Subject had approached the van and the pedestrian exited the van and handed her the keys. (Hearing testimony of the Subject and Justice Center

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<sup>3</sup> There were some discrepancies in the details of how the Service Recipients responded to the moving van and in which direction the van rolled, however findings of fact regarding these matters are unnecessary for this analysis.

Exhibit 6 at page five)

12. Thereafter, the Subject contacted the AOD and reported that there may be a mechanical issue with the van. The Subject requested that the AOD assist her in arranging that the Service Recipients' parents come outside to retrieve the Service Recipients and their medication so that she would not have to exit the vehicle again. (Hearing testimony of the Subject)

13. When the Subject returned the van to the facility, she filled out a form to report that the van may have had a mechanical issue. (Hearing testimony of the Subject)

### **ISSUES**

- Whether the Subject has been shown by a preponderance of the evidence to have committed the act or acts giving rise to the substantiated report.
- Whether the substantiated allegation constitutes abuse and/or neglect.
- Pursuant to Social Services Law § 493(4), the category of abuse and/or neglect that such act or acts constitute.

### **APPLICABLE LAW**

The Justice Center is responsible for investigating allegations of abuse and/or neglect in a facility or provider agency. SSL § 492(3)(c) and 493(1) and (3). Pursuant to SSL § 493(3), the Justice Center determined that the initial report of neglect presently under review was substantiated. A "substantiated report" means a report "wherein a determination has been made as a result of an investigation that there is a preponderance of the evidence that the alleged act or acts of abuse or neglect occurred..." (Title 14 NYCRR 700.3(f))

The abuse and/or neglect of a person in a facility or provider agency is defined by SSL § 488(1). Under SSL § 488(1)(h) neglect is defined as:

"Neglect," which shall mean any action, inaction or lack of attention that breaches a custodian's duty and that results in or is likely to result in physical injury or serious or protracted impairment of the physical, mental or emotional condition of a service recipient. Neglect shall include, but is not limited to: (i) failure to provide proper supervision...

Substantiated reports of abuse and/or neglect shall be categorized into categories pursuant to SSL § 493(4), including Category 3 which is defined as follows:

(c) Category three is abuse or neglect by custodians that is not otherwise described in categories one and two. Reports that result in a category three finding shall be sealed after five years.

The Justice Center has the burden of proving at a hearing by a preponderance of the evidence that the Subject(s) committed the act or acts of abuse and/or neglect alleged in the substantiated report that is the subject of the proceeding and that such act or acts constitute the category of abuse and/or neglect as set forth in the substantiated report. Title 14 NYCRR § 700.10(d).

If the Justice Center proves the alleged abuse and/or neglect, the report will not be amended and sealed. Pursuant to SSL § 493(4) and Title 14 NYCRR 700.10(d), it must then be determined whether the act of abuse and/or neglect cited in the substantiated report constitutes the category of abuse and/or neglect as set forth in the substantiated report.

If the Justice Center did not prove the abuse and/or neglect by a preponderance of the evidence, the substantiated report must be amended and sealed.

### **DISCUSSION**

The Justice Center has established by a preponderance of the evidence that the Subject committed the act described as Allegation 1 in the substantiated report. Specifically, the evidence establishes that the Subject committed an act of neglect under SSL § 488(1)(h) in that the Subject breached her duty to five Service Recipients by failing to provide proper supervision,



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during which time she left them unattended in a vehicle with the keys in the ignition and the engine running.

In support of its substantiated findings, the Justice Center presented evidence obtained during the investigation. (Justice Center Exhibits 1-7) The investigation underlying the substantiated report was conducted by facility Continuous Performance Improvement (CPI) Coordinator ██████████, who testified on behalf of the Justice Center.

The Subject testified at the hearing on her own behalf and provided no other evidence.

CPI Coordinator ██████████ interrogated the Subject on ██████████ and obtained a written statement (Justice Center Exhibit 5 at page 10) from the Subject on ██████████. While there was no recording of the ██████████ interrogation, CPI Coordinator ██████████ testified that the Subject admitted to her that she had left five Service Recipients alone in the facility van with the keys in the ignition and the engine running. The Subject admitted that fact in her hearing testimony as well.

The Subject testified that, although in this instance she had left the van to conduct personal business, she would have had to leave the Service Recipients alone in the van eventually anyhow. Because she was the only staff member transporting the Service Recipients and it is a facility requirement that medication be handed directly to the receiving adult when dropping off service recipients to their homes, she would have had to get out of the van at each drop-off, thereby leaving some of the Service Recipients alone.

The Subject testified that because of the incident, she was afraid to leave the van. As a result, she implemented a system wherein she telephoned the AOD when she arrived at a Service Recipient's home and the AOD contacted the receiving adult and directed the adult to come outside to the van to receive the Service Recipient and medication.

There was also credible evidence in the record that the Subject allowed the Service Recipients to carry their own medication to the receiving adult when the adult did not come outside to the van. (Justice Center Exhibit 5 at page 10)

Accordingly, the Subject's contention that she would have had no choice but to exit the van and leave the Service Recipients alone was contradicted by her own arrangements and actions. She managed to conduct the remainder of her business that day without leaving the Service Recipients alone in the van, which disproves her own assertion of the inevitability of having to leave the Service Recipients unsupervised. Furthermore, the Subject did not just leave the Service Recipients unsupervised in a parked vehicle, the Subject left the Service Recipients unsupervised in a parked vehicle with the keys in the ignition with the engine running, which created a much more dangerous situation.

The Subject testified that she left the keys in the ignition with the engine running because it was a cold and rainy day, and she was concerned about the windshield fogging up and the Service Recipients getting cold while she was out of the van. However legitimate these considerations may have been, the Subject's concerns should not have outweighed the overriding and paramount interest of maintaining a safe environment for the Service Recipients under her care.

In her hearing testimony, the Subject admitted that her conduct may have been bad judgment, which is exactly what it was. The Subject had the duty to provide proper supervision to the Service Recipients who were in her care, and her act of leaving the Service Recipients unsupervised in a running car was a breach of that duty.

While there was no evidence that the Subject's failure to supervise the Service Recipients actually resulted in physical injury, or serious or protracted impairment of the physical, mental or

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emotional condition of the Service Recipients, such evidence is not necessary for a finding of neglect. In this case, it was extremely fortunate that no harm came to the Service Recipients, especially in light of the fact that, in the Subject's absence, they were all compelled to jump from the one unlocked door of the moving vehicle. The Subject's breach of duty to the Service Recipients was certainly likely to result in their physical injury or serious or protracted impairment of their physical, mental or emotional condition.

Accordingly, in the final analysis, based on all of the evidence, it is concluded that the Justice Center has met its burden of proving by a preponderance of the evidence that the Subject committed the neglect under SSL § 488(1)(h), as specified in Allegation 1 of the substantiated report.

The report will remain substantiated. The next issue to be determined is whether the substantiated report constitutes the category of neglect set forth in the substantiated report. Based upon the totality of the circumstances, the evidence presented and the witnesses statements, it is determined that the substantiated report is properly categorized as a Category 3 act. A substantiated Category 3 finding of abuse and/or neglect will not result in the Subject's name being placed on the VPCR Staff Exclusion List and the fact that the Subject has a Substantiated Category 3 report will not be disclosed to entities authorized to make inquiry to the VPCR. However, the report remains subject to disclosure pursuant to NY SSL § 496 (2). This report will be sealed after five years.

**DECISION:** The request of ██████████ that the substantiated report dated ██████████, ██████████ be amended and

sealed is denied. The Subject has been shown by a preponderance of the evidence to have committed neglect.

The substantiated report is properly categorized as a Category 3 act.

This decision is recommended by Sharon Golish Blum, Administrative Hearings Unit.

**DATED:** March 18, 2016  
Plainview, New York



Sharon Golish Blum, Esq.  
Administrative Law Judge